Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

BREAST AND CERVICAL SCREENING FORM

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Client Name:		Phone Number:	State ID:
Social Security Number:	Date of Birth:	Admin Site #:	❑ Revised

Cervical Cancer Screening Results

Date of Pap test MM / DD /YYYY

Pap Specimen type ❑ Liquid ❑ Conventional

Adequacy of Pap speciman ❑ Satisfactory ❑ Unsatisfactory

Result of Screening Pap test ❑ Negative (intraepithelial lesion/malignancy) ❑ ASC-US ❑ Low grade SIL (including HPV changes)

❑ ASC-H ❑ High Grade SIL ❑ Squamous Cell Carcinoma ❑ Abnormal Glandular Cells

Date of HPV/DNA test MM / DD /YYYY

High Risk HPV/DNA test results if done ❑ Positive ❑ Negative

Paid by MCCP ❑ Pap test ❑ YES ❑ NO

❑ HPV/DNA test ❑ YES ❑ NO

Respond for ALL clients screened for cervical cancer

Has the client had a hysterectomy? ❑ YES ❑ NO

If 'Yes' was the hysterectomy due to cervial neoplasia? ❑ YES ❑ NO

Is the cervix still present? ❑ YES ❑ NO

a client who has had a hysterectomy is eligible for an MCCP Pap test if the hysterectomy was due to cervial neoplasia of the cervix is still present

Reason for Pap Test ❑ Routine screening ❑ Surveillance (follow-up of prev abnormal) ❑ Done outside MCCP (diagnostics only)

❑ Not done (diagnostics only) ❑ Breast record only

Date referred to MCCP for diagnostic workup MM / DD / YYYY

Additional procedures ❑ Not Planned, normal follow-up ❑ Planned, futher diagnostic tests needed

Recommended cervical cancer screening intercal for this client ❑ Short term follow-up (abnormal protocol) MM / DD /YYYY

❑ Every 3 yrs (Age 21-65) MM / DD /YYYY ❑ Every 5 yrs, w/HPV (Age 30-65) MM / DD /YYYY

Recommendation/Comments:

Provider's signature:	Print Provider's Name:

Breast Cancer Screening Results

Date of Clinical Breast Exam MM / DD / YYYY

Clinical Breast Exam (CBE) findings

❑ Normal exam ❑ Benign findings ❑ Abnormal (suspicious for cancer) ❑ CBE not done

Date of mammogram MM / DD / YYYY

Mammogram type ❑ Digital ❑ Conventional

Mammography test results - BI-RAD Categorites

❑ Negative (1) ❑ Benign (2) ❑ Probably benign short interval follow-up suggested (3)

❑ Suspicious Abnormality (4) ❑ Highly suggestive of malignancy (5) ❑ Assessment imcomplete (0)

Paid by MCCP ❑ CBE ❑ YES ❑ NO

❑ Mammogram ❑ YES ❑ NO

Reason for Mamography Test ❑ Routine screening ❑ Evaluate symptoms, positive CBE/prev abnormal mammogram

❑ Done outside MCCP (diagnostics only) ❑ Not done (only received CBE or diagnostics) ❑ Cervical record only

Date referred to MCCP for diagnostic workup MM / DD / YYYY

Additional procedures ❑ Not Planned, normal follow-up ❑ Planned, futher diagnostic tests needed

Recommended breat cancer screnning intercal for this client ❑ Every 2 years MM / DD /YYYY

❑ Short term follow-up abnormal protocol (personal history/1st degree family history of pre-menopausal breast cancer) MM / DD / YYYY

Recommendation/Comments:

Provider's signature:	Print Provider's Name: